FACTORS AFFECTING CONTRACEPTIVE PREVALENCE RATE IN SAMARAHAN DISTRICT, SARAWAK, MALAYSIA

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FACTORS AFFECTING CONTRACEPTIVE PREVALENCE RATE IN SAMARAHAN DISTRICT, SARAWAK, MALAYSIA

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# TABLE OF CONTENTS

ACKNOWLEDGEMENTS ................................................................. i
TABLE OF CONTENTS ................................................................. ii
LIST OF TABLES ............................................................................ v
LIST OF FIGURES .......................................................................... vii
ABSTARCT ...................................................................................... viii
ABSTRAK ....................................................................................... ix

CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW ................. 1
  1.1.1 Introduction ........................................................................... 1
  1.1.2 Background of the Study Population ..................................... 5
  1.1.3 Significance of the Study ....................................................... 7
  1.2 Literature Review ..................................................................... 7
    1.2.1 Introduction ....................................................................... 7
    1.2.2 Prevalence of Contraceptive Use ....................................... 9
    1.2.3 Factors Associated with the Use of Contraceptives ............. 11
  1.3 Problem Statement ................................................................. 19
  1.4 Research Objectives .............................................................. 21
    1.4.1 General Objective ............................................................ 21
    1.4.2 Specific Objectives ......................................................... 21
  1.5 Research Hypotheses .............................................................. 22
  1.6 Research Questions ............................................................... 22
  1.7 List of Variables ...................................................................... 22
  1.8 Conceptual Framework .......................................................... 25

CHAPTER 2: METHODS AND MATERIALS .................................... 26
  2.1 Research Study Design .......................................................... 26
  2.2 The Study Population ............................................................ 26
  2.3 Place of Study ......................................................................... 26
  2.4 Sample Size Determination ................................................... 29
  2.5 Sampling Procedure .............................................................. 30
  2.6 Inclusion and Exclusion Criteria ........................................... 32
    2.6.1 Inclusion Criteria ........................................................... 32
    2.6.2 Exclusion Criteria ........................................................ 32
LIST OF TABLES

Table 1.1 Methods of contraception from Gynaecology Illustrated (Govan et al., 1993)…… 9
Table 3.1 Percentage distribution of socio-demographic characteristics (n=462) .............. 43
Table 3.2 Percentage distribution of socio-demographic characteristics (n=462) .............. 44
Table 3.3 Percentage distribution of the respondents by age at first marriage and duration of married life (n=462) ................................................................................................................ 45
Table 3.4 Percentage distribution of the respondents by number of living children and age of the last child .................................................................................................................................. 46
Table 3.5 Percentage distribution of the respondents by number of miscarriages and passed away (n=462) .............................................................................................................. 46
Table 3.6 Percentage distribution of the respondent’s use of contraception ...................... 48
Table 3.7 Percentage distribution of the respondents by current contraceptive use and socio-cultural characteristics ............................................................................................................. 51
Table 3.8 Percentage distribution of respondents by current contraceptive use and marital and reproductive history ................................................................................................................. 54
Table 3.9 Percentage distribution of the respondents by current contraceptive use and level of knowledge, fertility preferences, and husband-wife communication .............................................................................................................. 55
Table 3.10 Factors affecting contraceptive use: Binary Logistic Regression Analysis ........ 57
Table 3.11 Percentage distribution of respondents by knowledge of contraceptive methods (n=462) ...................................................................................................................... 59
Table 3.12 Percentage distribution of respondents by knowledge on side effects (n=462) ... 60
Table 3.13 Percentage distribution of the respondents by knowledge on source of getting contraceptives ............................................................................................. 61
Table 3.14 Percentage distribution of respondents’ knowledge on source of information on contraception .................................................................................................................. 62
Table 3.15 Percentage distribution of respondents’ knowledge of available contraceptive methods in the village/nearest clinic/hospitals .............................................................. 63
Table 3.16 Percentage distribution of the respondent’s total level of knowledge on contraception .......................................................................................................................... 64
Table 3.17 Percentage distribution of the respondents by level of knowledge on contraceptive and socio-cultural characteristics ................................................................. 67
Table 3.18 Percentage distribution of the respondents by level of knowledge on contraceptive and marital and reproductive history ................................................................. 69
Table 3.19 Percentage distribution of the respondents by current contraceptive use, fertility preferences and husband wife communication

Table 3.20 Percentage distribution of respondents by the level of knowledge of contraceptive and current contraceptive use, fertility preferences, and husband wife communication

Table 3.21 Percentage distribution of the respondents by fertility preferences (n=462)

Table 3.22 Percentage distribution of the respondent’s desired number of children and gender preferences (n=462)

Table 3.23 Percentage distribution of the respondents by fertility preferences socio-cultural characteristics

Table 3.24 Percentage distribution of the respondents by fertility preferences and marital and reproductive history

Table 3.25 Percentage distribution of the respondents by fertility preferences and level of knowledge, Husband wife communication and current contraceptive use

Table 3.26 Factors affecting fertility preference: Multinomial Regression Analysis

Table 3.27 Percentage distribution of husband wife approval to use contraception (n=462)

Table 3.28 Percentage distribution of husband wife communication pattern (n=462)

Table 3.29 Percentage distribution of persons and factors influencing the decision on contraceptive use among the respondents (n=462)

Table 3.30 Respondent’s perception on husband’s desire to have the same amount of children as respondent

Table 3.31 Percentage distribution of the respondents by husband wife communication and socio-demographic

Table 3.32 Percentage distribution of the respondents by husband wife communication and marital and reproductive history

Table 3.33 Percentage distribution of the respondents by husband wife communication with the level of knowledge, fertility preferences and current contraceptive use
LIST OF FIGURES

Figure 1.1 Map of Sarawak ....................................................................................................... 5
Figure 2.1 Participants' enrolment diagram ............................................................................ 31
ABSTRACT

The contraceptive prevalence rate (CPR) is an important indicator in achieving the Millennium Development Goal (MDG) by 2015. Despite all the efforts to improve the contraceptive prevalence rate (CPR) in Malaysia after 1984, the CPR has levelled off at the range of 52% since then. In Sarawak, CPR increase slightly from 50.1% in 1989 to 53.0% in 2004. This was a cross-sectional study to determine the factors affecting the contraceptive prevalence rate. A total of 462 married women of reproductive age of 18 to 49 years old participated in this study. The prevalence of contraceptive use was 42.9%. The most popular method was oral contraceptive pills (55.1%) for modern methods and the rhythm method (4.5%) for traditional contraceptive methods. The main reason for using was for birth spacing (47.6%). The significant factors associated with the contraceptive use were the wife's age (p<0.001), family size (p<0.045), number of living children (p<0.003), age at first marriage (p<0.046), duration of marriage (p<0.003), age of last child (p<0.001) and husband wife communication (p<0.001). However, there were no significant differences with the husband's age, the women's history of miscarriages, race, religion, occupation, education level, income, total household income, fertility preferences and the level of knowledge on contraception. Further studies needed to assess other factors in relation to the contraceptive use for more comprehensive and culturally acceptable community-based family planning program could be implemented. The activities must emphasize on the focus risk group as in the study findings. Special efforts should be made to emphasize husband's shared responsibility and promote their active involvement in family planning programmes to ensure a long-term permanent effect on contraceptive use.

Keyword: contraceptive use, family planning, prevalence, reproductive aged women
ABSTRAK

FAKTOR-FAKTOR YANG MEMPENGARUHI KADAR PREVALENS KONTRASEPTIF DI DAERAH SAMARAHAN, SARAWAK, MALAYSIA

Kadar prevalens kontraseptif merupakan petunjuk penting dalam mencapai Matlamat Pembangunan Milenium (MDG) menjelang 2015. Walaupun banyak usaha telah dijalankan untuk meningkatkan kadar prevalens kontraseptif di Malaysia selepas tahun 1984, kadar prevalens kontraseptif masih tetap berada pada tahap 52% sejak itu. Kadar prevalens kontraseptif di Sarawak meningkat sedikit dari 50.1% pada tahun 1989 ke 53.0% pada tahun 2004. Ini merupakan satu kajian hirisan lintang quantitatif untuk menentukan faktor-faktor yang meramalkan penggunaan kontraseptif semasa. Sebanyak 462 wanita berumur reproduttif antara 18 hingga 49 tahun yang telah berkahwin menyertai kajian ini. Kadar prevalens penggunaan kontraseptif adalah 42.9%. Kaedah yang paling popular adalah pil perancang (55.1%) untuk kaedah kontraseptif moden; dan kaedah kitaran (4.5%) bagi kaedah kontraseptif tradisional. Sebab-sebab utama menggunakan pil perancang adalah untuk menjarakkan kelahiran (47.6%). Umur isteri (p<0.001), saiz keluarga (p<0.045), bilangan anak-anak yang hidup (p<0.003), umur perkahwinan pertama (p<0.046), tempoh perkahwinan (p<0.003), umur anak yang terakhir (p<0.001) dan komunikasi suami isteri (p<0.001) telah didapati penting dalam mempengaruhi penggunaan kontraseptif. Walau bagaimanapun, tidak terdapat perbezaan yang signifikan di antara penggunaan kontraseptif dengan umur suami, sejarah keguguran, bangsa, agama, pekerjaan, tahap pendidikan, pendapatan sendiri, jumlah pendapatan isi rumah, pilihan kesuburan dan juga tahap pengetahuan responden mengenaikontrasepsi. Kajian lanjut diperlukan untuk menilai faktor-faktor lain yang
mempengaruhi penggunaan kontraseptif, supaya program perancangan keluarga yang lebih komprehensif dan diterima budaya boleh dirancang. Program perancangan keluarga perlu memberi penekanan kepada kumpulan berisiko tinggi terutamanya di kalangan wanita berusia 25 hingga 44 tahun, wanita yang mempunyai saiz keluarga 1 hingga 3 orang, umur perkahwinan pertama berusia lebih daripada 20 tahun, tempoh berkahwin lebih daripada 10 tahun, wanita yang mempunyai lebih daripada 4 anak yang hidup, dan wanita yang mempunyai anak terakhir yang berumur 10 tahun dan ke atas. Ia juga disyorkan bahawa usaha khas perlu dibuat untuk menekankan tanggungjawab dan penglibatan yang aktif suami dalam program perancangan keluarga untuk memastikan kesan jangka panjang yang kekal dalam penggunaan kontraseptif.

Kata kunci: penggunaan pil perancang, perancangan keluarga, prevalens, wanita berumur reproduktif
CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

1.1.1 Introduction

Family planning is a method which allows spouses to anticipate and attain the desired number of offspring (children) as well as allowing for the timing and spacing of these births. It is achieved through the use of various contraceptive methods (WHO, 2012). A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being, as well as, on the outcome of each pregnancy (WHO, 2012). As many as three out of ten maternal deaths could be prevented with family planning. This would allow women to delay motherhood, space their births, avoid unintended pregnancies, avert abortion and halt child bearing once they have reached their desired family size (Collumbien et al., 2004). However, a worldwide estimated of 137 million women still have unmet need for family planning, that is, they are not using any method of family planning and report that they want to avoid pregnancy (Singh et al., 2009).

Prior to 1966, family planning services in Malaysia were state run by various family planning associations and largely confined to large urban centres. In 1966, in conjunction with the First Malaysia Plan, the National Family Planning Board was established to plan, execute and co-ordinate all national family planning activities in the country. The National Planning Program was launched, making family planning a national policy. This program was targeted at increasing the number of family planning acceptors to improve maternal and child health as well as to decelerate the rate of population. It began by providing contraceptive services mainly to the urban areas and then later expanded to the rural areas by integrating family planning with primary health care services of the Ministry of Health in the early 1970s (Aziz et
Impact from the program, the rate of population growth had decreased from 3% in 1966 to 2% in 1985.

Despite all the efforts to improve the contraceptive prevalence rate after 1984, the Contraceptive Prevalence Rate (CPR) has maintained at a stagnant present day range of 52% ever since 1984, after enjoying a drastic increase from 1966 at 8% to 1974 at 36% and further on to 52% in 1984. The CPR in Malaysia is still low compared to other countries in the East Asia-Pacific region at 50% for all methods and 33% for modern methods since the mid 1980’s (UNCTM, 2011).

In 2005, the Economic Planning Unit (EPU) in the Prime Minister’s Department collaborated with the United Nations’ Country Team Malaysia (UNCTM) reviewed the Millennium Development Goals (MDG) in Malaysia. It highlighted policy initiatives and programs that had contributed to Malaysia’s achievements and outlined challenges going forward especially in areas that were lacking. MDG 5 emphasizes on the improvement of maternal health. MDG 5A is a target set to reduce by three quarters the maternal mortality ratio achieved between 1990 and 2015. MDG 5B is a target to achieve universal access to reproductive health by 2015 (UNCTM, 2011). Two of the important indicators in achieving universal access in reproductive health by 2015 include increasing contraceptive prevalence rate and reducing the unmet need for family planning. However, for the past 19 years, Malaysia’s CPR has been stagnant at 52%. Data showed 24.7% for unmet need for family planning in Peninsular Malaysia for 2009. In both rural and urban areas, the contraceptive use prevalence rate was highest amongst Chinese and lowest amongst Malays, with Indians in between (Tey, 1988). However, there is no data for the eastern states of Sabah and Sarawak.
To achieve the MDG targets, the indicators should show an improvement and further research should be done in relation to find the factors of the stagnant CPR and as to whether reproductive aged couples prefer to practice family planning or not.

In the past few years, more emphasis was placed on the factors influencing family planning including demographic characteristics, psychological characteristics, knowledge, attitudes and practice (Ibnouf et al., 2007; Nidiaye et al., 2003). Social factors had also been studied extensively. These include the organization of contraceptive health care, the quality of information given by professionals and the influence of the mass media had shown to play a significant role in the contraceptive choices (Speizer et al., 2001; Ozlem et al., 2006).

Spousal communication is the first step in a rational process of fertility decision making preceding such decisions as family size and the increase of contraceptive use (Hollerbach, 2000). Deficiencies in communication activities are seen to be one of the limiting factors that hinder the success of family planning programs (Raju, 1987). Information on the significant association between spousal decision making and the practice of family planning is limited especially in Sarawak.

For the assumption that women bear the risks and burdens of pregnancy and childbearing and most modern contraceptives are available for women, family planning in the past has always focused on women or the wife instead of men or the husband in family planning programs. Therefore, the clinic based services for family planning has made it difficult to include men and catered more to the women (Wegner, 1998). Family planning services like in Sarawak have often been offered in Maternal and Child Health (MCH) clinics and not in the outpatient clinics. Many men and the husbands see MCH clinics only to cater women and children need, and feel
uncomfortable seeking information or services in that setting (Danforth, 2004; Gallen et al., 2001; Masson and Taj, 2001). Men play a vital role in family planning decisions. In some culture, men or the husband plays a dominant role. Couples who talk to each other about family planning reach healthier decisions and use contraception wisely and effectively (Beckman, 2002). In contrast, without considering their partner’s decision opinion, their actions can have unhealthy and even dangerous impact. Therefore, it is important to have a husband and wife communication before deciding to choose a choice of family planning.

Education can bring about appropriate behavioural changes and improve participation in the use of family planning (Moronkola et al., 2006). Free choice and promotion of a wide range of effective contraceptives, including responsible counselling, will improve the quality of reproductive health or family planning services. This will avoid unplanned pregnancies, reduce complications, injury and of maternal mortality could fall by one-fourth (Moronkola et al., 2006).

Disparities in contraceptive prevalence occur along socioeconomic, geographical and ethnic boundaries. In all countries, contraceptive use increases with women’s education and health status. Contraceptive Prevalence Rate (CPR) and contraceptive mix patterns are different between rural and urban areas, and vary among regions and provinces. In 2003, the Contraceptive Prevalence Rate (CPR) of married women in Thailand was estimated to be as high as 83 percent in the northern region, but approximately 70 percent in the southern region where the Malay population is concentrated (CCR and ARROW, 2005). In Indonesia’s most populous island of Java, contraceptive use ranged from 61 percent in West Java to 67 percent in the Special Region of Yogyakarta (BPS and Macro International, 2008). The Central
Highlands of Viet Nam, with their diverse ethnic minority population, show the lowest CPR in the country (Teerawattananon, 2008).

There are many factors affecting the use of contraception and which are essential in determining the increase use of contraception in the future. Continued progress and improvement in these areas should provide the impetus for the uptake of contraception in Sarawak.

1.1.2 Background of the Study Population

Sarawak is the largest state in Malaysia with an area of 124 000 km$^2$. It has a population of approximately 2 million and it is the least densely populated state among 13 states in Malaysia. The capital city of Sarawak is Kuching. There are 11 divisions with 31 districts in Sarawak (Department of Statistics Malaysia Sarawak, 2010). Refer to Figure 1.1.

Figure 1.1 Map of Malaysia
Samarahan Division consists of four administrative districts namely Samarahan, Asajaya, Serian and Simunjan Districts. The population of Samarahan Division in the year 2000 was estimated to be 244,087 (Department of Statistics Malaysia Sarawak, 2010). Kota Samarahan District is the largest and the second most populated districts among the four districts in the Samarahan Division with an area of 407.08 km² wide.

Kota Samarahan District is situated 32 km from Kuching City. There are 44 villages in Kota Samarahan District, and with a population of 85,495, and 16,635 households in 2010 (Samarahan District Office, 2012), and 12,744 reproductive women aged 18-49 years old (Samarahan Divisional Health Office, 2012). The population in Samarahan consisted of mostly Malay (20,853) and Ibans (9,300). Family planning services are offered in maternal and child care (MCH) clinics in Sarawak. There are 3 clinics that offer MCH and family planning services in Samarahan District, which are KKIA Kota Samarahan (highest attendances), KKIA Sambir, and KKIA Sebisik. Contraceptive methods available in these clinics are condoms (male), oral contraceptive pills, injectable contraceptives and IUCD (Samarahan Divisional Health Office, 2012).

This study was conducted in four villages in Kota Samarahan District namely; Kampung Nangka, Kampung Entingan, Kampung Pinang, and Kampung Tanjung Bundong. These four villages were chosen among the forty four villages in Kota Samarahan District for this study because:

1) To capture reproductive age women who not only go to MCH, but also those who did not attend MCH clinics;

2) The villages which had among the highest population of women of reproductive age in a village;
3) Easy access to the communities selected as they are linked by roads.

1.1.3 Significance of the Study

This study will contribute to the understanding of the factors affecting the choice of contraceptive use in the communities in Samarahan. The outcome of this study will be used to improve the implementation of family planning programmes by identifying the different factors that affect the use of contraception and the unmet needs of family planning.

Finally, this study will determine the existing contraceptive prevalence rate in Samarahan so that a more tailored family planning programme could be planned in the future in order to increase contraceptive use among the communities. The findings of this study will also give valuable information for improving the contraceptive choice for people in areas similar to Samarahan.

1.2 Literature Review

1.2.1 Introduction

Family planning is the planning of when to have children and the use of birth control and other techniques to implement such plans (WHO, 2012). Family planning is used as a synonym for the use of contraceptives and includes a wide variety of methods and practices. It is most usually applied to a female-male couple who wish to limit the number of children they have and/or to control the timing of pregnancy (also known as spacing children) (Kartz et al., 2007).
Family planning services are defined as educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved (US Department of Health, 2000). It is not only affecting the women's fertility but also the countries' vital statistics such as maternal and children morbidity and mortality rates as well as socioeconomic and nutritional status of the family and health care of infants, children and women.

Today, the voluntary control of fertility is important to modern society and brings great benefits. The effective control of reproduction can be essential to a woman's ability to achieve her own individual goals as well as contribute to her sense of well-being. By lengthening the time between pregnancies, birth control can also improve adult women's delivery outcomes and the survival of their children (Cleland et al., 2012). Safe sex, such as the use of male or female condoms, can also help prevent transmission of sexually transmitted diseases (Taliaferro et al., 2011; Chin et al., 2012). Contraceptive use in developing countries has cut the number of maternal deaths and could prevent the demand for birth control (Cleland et al., 2012; Ahmed et al., 2012).

There are many different types of contraception methods available today enabling people to be able to find the right method. Ideally we should have reached the stage where unplanned pregnancies are rare because there are so many good birth control methods available in Malaysia. Yet, there are many unintended pregnancies in the world (Govan et al., 1993). For females, contraceptives can be divided into six methods, namely barrier methods, hormonal methods, intrauterine devices, natural methods, spermicides and surgical methods (Table 2.0). As for males, there are condoms and vasectomy for contraception (Govan et al., 1993). Methods of
contraception practiced today can also be divided into "modern" and "traditional" ones. The former refers to clinic supplied methods such as voluntary surgical sterilization, the IUD, oral contraceptives, implants, injectables, condoms, and vaginal barrier methods. The main traditional or non supply methods are periodic abstinence and withdrawal, as well as traditional folk methods with uncertain efficacy.

Table 1.1: Methods of contraceptives from Gynaecology Illustrated (Govan et al., 1993)

<table>
<thead>
<tr>
<th>Used by</th>
<th>Methods</th>
<th>Contraceptives</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEMALE</td>
<td>Barrier Methods</td>
<td>Diaphragm, cervical cap, female condom.</td>
</tr>
<tr>
<td></td>
<td>Hormonal Methods</td>
<td>• Oral contraceptive (Combined oestrogen/progesteron and progesteron only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Depot progestogens (injections and subcutaneous silicone implants)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vaginal (Silicone rings releasing estrogen and progesterone)</td>
</tr>
<tr>
<td></td>
<td>Intra-uterine device</td>
<td>Inert, copper bearing, progesterone</td>
</tr>
<tr>
<td></td>
<td>Natural Methods</td>
<td>Rhythm or billings, breastfeeding</td>
</tr>
<tr>
<td></td>
<td>Spermicides</td>
<td>Creams, films, foams, jellies, pessaries, sponges</td>
</tr>
<tr>
<td></td>
<td>Surgical methods</td>
<td>• Tubal ligation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Laparoscopies sterilization (rings, clips, bipolar diathermy)</td>
</tr>
<tr>
<td>MALE</td>
<td>Barrier Methods</td>
<td>Condoms</td>
</tr>
<tr>
<td></td>
<td>Surgical methods</td>
<td>Vasectomy</td>
</tr>
</tbody>
</table>

1.2.2 Prevalence of Contraceptive Use

Contraceptive prevalence rate is the percentage of women married or in-union aged 15 to 49 who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of the method. The contraceptive prevalence rate is one of the proxy indicators for access to reproductive health and family planning (UNPD, 2012). Data from United Nation Population Division Department of Economic and Social Affairs showed that the world’s contraceptive prevalence rate for 2009 was 56.1%. Australia and New Zealand had the highest average contraceptive prevalence (71.1%), while Melanesia, Micronesia and Polynesia had the
lowest contraceptive prevalence rate (28.6%) in the world for 2009. South East Asia on the other hand recorded 54.7% contraceptive prevalence rate (UNPD, 2012).

Increased access to high quality family planning services and information has been an important factor in improving maternal health in Malaysia. The contraceptive prevalence rate doubled from 26.3% in 1974 to 52% in 1984, but stayed at about 52% after that (NPFDB, 2004). In 2004, Malaysia's contraceptive prevalence rate was 51.9%. As for Sarawak, the contraceptive prevalence rate rose slightly from 50.1% in 1989 to 53.0% in 2004 (NPFDB, 2004). Among married women of reproductive age using modern methods in 2004, 26.8% took the pills, 14% used condoms and 12.7% did tubal ligation. The lowest prevalence of modern methods is in Terengganu and Kelantan. The rhythm method was the most popular traditional method used in Malaysia with the proportion increasing from 10.8% in 1974 to 17.8% in 2004 (NPFDB, 2004).

Couples have the right to choose the timing and number of children and the method of family planning. An unmet need for contraceptive use is when a couple wishes to stop or delay childbearing but not using any method of contraception for various reasons. Chinese, Malays and Indians had the same unmet needs for family planning but differences can be seen in the contraceptive prevalence rate where a higher proportion of Chinese and Indians wanting to stop childbearing compared to the Malays (NPFDB, 2004). Among women not wanting any more children but not practicing family planning, 24.5% had an unmet need. The highest rate was among the 45-49 age group (41.7%) followed by the 40-44 age group (22.7%) and the 20-24 age group (21.4%). Data also showed that there is slightly higher proportion of rural (30.6%) than urban women (22%) who had unmet needs in family planning (NPFDB, 2004).
A study in Qatar, showed that 67.7% of women who currently practice family planning are using modern methods, while 35.4% of them are using traditional or natural methods. Intra-uterine contraceptive devices (IUCDs) (32.9%) and pills were the most popular while condoms (7.8%), breastfeeding (4.5%), withdrawal (4.5%) and injectable contraceptives (2.7%) were the least common in current practice of family planning in the study (Arbab et al., 2009). This study also revealed that 15.9% of women who currently used contraceptives reported experiencing one or more side effects of the method. The most common complications in the women were bleeding (4.1%), severe headache (3.1%), abdominal pain (2.3%) and vaginal discharge (2%).

1.2.3 Factors Associated with the Use of Contraceptives

Many methods of contraception of great varying efficiency are in use. The ideal method should be safe, without risk to health, acceptable, inexpensive and should not interfere with the enjoyment of coitus. A patient’s choice of contraceptive method involves factors such as efficacy, safety, cost and personal considerations.

A study in Jimma town, Ethiopia revealed that the type of partnership, husband’s age and wife’s employment have no statically significant association with a couple’s contraception use. The author also showed that couples who were Christian by religion have higher contraceptive use as compared to the Muslims (Haile & Enquesellassie, 2006). While a study in India showed that percentage of women knowing all the modern methods of contraception is higher among Muslims compared to other women (Narzary, 2009). On the other hand, Omo-Aghoja et al., (2009) in their study found that religion were not significantly correlated to the increase of contraceptive use.
Gizaw and Regassa (2011) in their study showed that there are significant effects to the total number of children, literacy status of respondents, women’s approval of family planning, spousal communication and media exposure to the contraceptive use. On the contrary, this study also had shown that there was a significant relationship between current contraceptive use to age and family planning approval of husband/partners. However, a study in Qatar (Arbab et al., 2009) revealed that practice of family planning was strongly associated with women aged 30-39 years and husbands age’s group between 30-39 years. Narzary (2009) and Arbab et al. (2009) revealed that as the marital duration increases, percentage of women using contraception also steadily increases. There was a strong positive correlation between age at first marriage and age of reproductive women have been found to have a significant effect on contraception use by both cross-tabulation and logistic regression analyses done in a study by Khan, Hossain and Nazmul (2012). The age at first marriage, the adolescent women whose age is less than or equal to 15 years practice contraceptive method more times than the adolescent women whose age above 15 years. This indicates the women practice contraceptive method from their starting of marital life (Khan et al., 2012).

In Kazakhstan, Kyrgyz Republic, Uzbekistan, Bulgaria, Turkey, Tunisia and Switzerland, abortion incidence declined as prevalence of modern contraceptive use rose. In the other hand, Cuba, Denmark, the Netherlands, the United States, Singapore and the Republic of Korea, the levels of abortion and contraceptive use rose simultaneously. After fertility levels stabilized in several of the countries that had shown simultaneous rises in contraception and abortion, contraceptive use continued to increase and abortion rates fell (Marston and Cleland, 2003).